To note

Report of the Revalidation Implementation Advisory Board

Issue
1. This paper reports the latest discussions at the Revalidation Implementation Advisory Board, noting particularly the issues considered at its meetings on 3 March 2014 and 18 June 2014.

Recommendation
2. The Strategy and Policy Board is asked to note the report and the latest discussions at the Revalidation Implementation Advisory Board.
Report of the Revalidation Implementation Advisory Board

Issue

3 As outlined in its statement of purpose, we established the Revalidation Implementation Advisory Board (RIAB) ‘To provide advice to our Chief Executive during the implementation of revalidation, in order to support the GMC in fulfilling its regulatory objectives’. Its members are representatives from primary, secondary and independent healthcare across the UK, as well patient organisations and the GMC. Sir Keith Pearson is RIAB’s independent chair.

4 RIAB has met twice since the last report to the Strategy and Policy Board. The minutes of meetings on 3 March 2014 are at Annex A and 18 J une 2014 at Annex B. RIAB approved the minutes of the March meeting when it met in June and we subsequently published these on our website. We will ask RIAB to approve the minutes of the June meeting (which the Chair has reviewed) when it meets on 30 September 2014.

Reviewing progress with revalidation

5 At each meeting, RIAB has considered a progress report containing our latest revalidation statistics and information on policy developments. Recently this has related to processes for doctors without a connection and our ongoing work to put in place a framework for how we respond if, in exceptional circumstances, we receive information that causes concern about local systems.

6 In March we assured members of our readiness for the substantial increase in recommendations due from April 2014. We also heard from representatives of each UK country and the independent sector about their readiness for this move into year two of revalidation. Reflecting on this at its meeting in June, RIAB agreed that the transition had been smooth, with no problems presented by the increase in recommendations, either by responsible officers or the GMC.

7 We continue to develop the type of revalidation statistics and the level of detail made available both to RIAB and published more widely on our website, with RIAB advising on information they find of particular value. As we begin to see higher volumes of recommendations, the scope for drawing meaningful conclusions increases. However, we continue to emphasise the limitations of the data currently available and any influencing factors (the number of trainees receiving deferrals, for example, due to changes in their Certificate of Completion of Training dates).

Evaluating revalidation

8 Having presented the revalidation evaluation framework in December 2013, we have kept RIAB informed about the tender process for the supplier to carry out the evaluation. Members have expressed their keenness to be fully engaged in this
programme of work. With the supplier now appointed, we will be inviting them to run a workshop with RIAB as part of the initial stages of the evaluation at the meeting in September 2014.

**Future meetings**

RIAB will meet on 30 September, and 17 December 2014. We will consider with members whether to extend the lifespan of RIAB for a further twelve months at the December meeting.
Supporting information

How this issue relates to the corporate strategy and business plan

The work of the Revalidation Implementation Advisory Board supports Strategic aim 2 ‘Help raise standards in medical education and practice’ and strategic aim 5 ‘Work better together to improve our overall effectiveness, our responsiveness and the delivery of our regulatory functions’.

If you have any questions about this paper please contact: Una Lane, Director of Registration and Revalidation, ulane@gmc-uk.org, 020 7189 5164.
Minutes of the Revalidation Implementation Advisory Board meeting on 03 March 2014*

Members present

Malcolm Lewis, Chair (in the absence of Sir Keith Pearson)

David Black
Nick Clarke
Allan Coffey
Frances Dow
James Fisher
Sol Mead

Val Millie
Mark Porter
Sally Taber
Jan Warner
Paddy Woods

Others present

Clare Barton, Assistant Director Revalidation and Specialist Applications
Rosanna Bate, Senior Policy Executive, BMA
Jon Billings, Assistant Director Regulatory Development and Evaluation
Catherine Evans, Board Secretary

Philip Finn, Head of Regulatory Development and Evaluation
Judith Hulf, Responsible Officer and Director Education and Standards

* These Minutes should be read in conjunction with the Board papers for this meeting, which are available on our website at http://www.gmc-uk.org
Chair’s business

1 Malcolm Lewis welcomed members and noted that he would be chairing the meeting in the absence of Sir Keith Pearson, who had sent his apologies. The Board had been notified of this arrangement in an email on 28 February 2014.

2 Since the last meeting Sir Keith Pearson had made visits to Cardiff, Cambridge and Surrey. He would reflect on these with the Board at the next meeting.

3 Apologies for absence were noted from Mike Bewick, Niall Dickson, Tony Falconer, Chris Jones, Una Lane, Sir Keith Pearson, Wendy Reid, and Ben Whur.

4 The following deputies attended the meeting:
   a James Fisher for Mike Bewick.
   b David Black for Wendy Reid.
   c Val Millie for Ian Finlay.

Minutes of the meeting on 18 December 2013

5 The Board approved the minutes as an accurate record.

Matters arising

6 Issues associated with trainee revalidation dates had been discussed by the UK Conference of Postgraduate Medical Deans (CoPMeD), but with no consensus emerging, the GMC had no plans to change the current process for trainee revalidation.

7 Noting the rationale for linking the Certificate of Completion of Training (CCT) and revalidation, the Board advised that changes should not be made solely to relieve administrative burden. It was the Board’s view that the scale of the issue needed to be clarified further by CoPMeD and any other potential solutions considered. The Board also suggested that the GMC’s evaluation of revalidation should take account of the experience of doctors in training.

Update on preparation for Year Two

8 Representatives of each UK country and the independent sector gave an update on revalidation and preparation for Year two. Jan Warner presented to the Board (rescheduled from the previous meeting). Noting Chris Jones’ apologies, the GMC would request a written update from Wales. The Chair noted that generally the first full year of revalidation seemed to have gone very well.
The Board noted the following updates:

a The GMC was confident that it had sufficient measures in place to deal with the increase in recommendations due from April 2014. A formal assessment had been carried out, and Council would be given assurance of readiness via a report to the GMC Performance and Resources Board on 10 March 2014.

b NHS England was awaiting confirmation of revalidation funding to enable recruitment for the coming year. The focus would then be on improving decisions, networks and consistency across the UK. This would be supported by a Framework for Quality Assurance for Responsible Officers and Revalidation. NHS England was also planning to roll out common revalidation software to all area teams to increase efficiency.


d In Northern Ireland a Responsible Officer (RO) Forum had taken place on 28 February 2014. Gaining patient feedback had been highlighted as the most challenging part of revalidation, with further work needed to address this.

e Scotland was rolling out the requirement to outsource appraisal in organisations with less than 15 staff.

f In year two Scotland’s focus would be on promoting annual appraisal and transition planning for the change to a five year revalidation cycle. Evaluation work would continue for another year, with the continuation of focused regulatory overview until the first full revalidation cycle was complete.

g For the independent sector, continuity of engagement and involvement with the NHS in England was seen as important, especially with the closure of the Revalidation Support Team. The lack of regulation of independent clinics in Scotland was also a continuing issue.

The Chair thanked members for their contributions.

GMC progress report

The Board considered a report giving an update on the GMC’s progress with implementing revalidation and publishing data. This included the planned increase in frequency of published data from quarterly to monthly from the start of year two and new information about suitable persons on the GMC website.

During discussion, the Board noted that there was not currently sufficient information to be able to look in detail at the underlying reasons for deferral amongst particular
groups of doctors. However, this could be looked into as part of the evaluation. Deferral was not indefinite, and where doctors’ revalidation had been deferred more than once it was mainly due to changes in trainees’ CCT dates.

**Route to revalidation for doctors without a prescribed connection or connection to an approved suitable person**

13 The Board considered a presentation giving the latest information from the GMC about revalidation for doctors without a prescribed connection or connection to an approved suitable person.

14 The Board advised that:

a. The approach taken would need to be proportionate, especially for doctors working in very specialist or non-clinical areas.

b. Due diligence around this revalidation route would be necessary to avoid its improper use.

15 In discussion, the Board noted:

a. The diverse nature of practice for those doctors without a prescribed connection or connection to a suitable person, for example doctors working wholly overseas, doctors working for mental health tribunals and coroners, among others. The GMC would build up more information about these doctors throughout the revalidation cycle.

b. That doctors would be encouraged to find an approved suitable person to support them with revalidation where possible, rather than use this alternative option.

**GMC evaluation of revalidation**

16 The Board considered the draft framework for evaluating revalidation, due for publication shortly, alongside updated pages of the GMC website (http://www.gmc-uk.org/doctors/revalidation/9610.asp). It also heard the latest from the GMC on the tender process to appoint a contractor to carry out the substantive evaluation work.

17 The Board advised that:

a. The evaluation should consider current activities and developments over the coming year to assess what is working well and where improvements could be made.

a. The various strands of research and evaluation being carried out across the UK need to be aligned to give a full picture of revalidation.
18 Members were invited to send any additional comments to the Board Secretary after the meeting.

19 During discussion, the Board noted that:

a The Prior Information Notice for the invitation to tender for the evaluation would be available on the Mytenders website within the next few days. The GMC would send the Board information about how to access it.

b Once the GMC had appointed a contractor, one of their areas of work would be to consider links with other evaluation, data and research. The Board would have a key role in helping to bring together the learning from this evaluation and research.

Managing intelligence about the systems underpinning revalidation and verifying the status of designated bodies

20 The Board considered information on GMC quality assurance mechanisms and the use of intelligence received around revalidation. The GMC also gave an update on work to verify the status of designated bodies. There were some organisations that were not currently designated but, under the regulations, should be, and others who wished to be designated bodies, but were not covered by the regulations.

21 The Board advised that:

a The system presented for managing intelligence was consistent and proportionate.

b There needed to be a way to verify designated bodies across the UK to help protect the integrity of the system.

c Consideration should be given to how to share intelligence, which was often gained through the GMC’s Employer Liaison Service, with other regulators.

d The GMC should take this work forward with delivery partners to confirm the approach, including respective roles.

22 In discussion, the Board noted that

a the GMC had put together a revalidation training pack for inspectors to help the process of linking in with other regulators, particularly the Care Quality Commission.

Any other business

23 David Black raised the question of how far organisations have to go to get information about trainees or locums from every organisation in which they practise. This needed to be proportionate, but as yet there appeared not to be a fixed solution.
The Board agreed that it was difficult to track this, and for trainees, advice would need to be sought from educational supervisors. More research was needed to assess the scale of the issue and whether any action was needed. David Black agreed to seek advice from CoPMeD.

24 The Board noted the time and date of its next meeting at 14:00 on Wednesday 18 June 2014.

25 As it was Allan Coffey’s last meeting representing the Revalidation Support Team, the Chair thanked him for his contributions. Sir Keith Pearson would be writing to him formally to thank him on behalf of the Board.

26 The Chair noted that Jon Billings would be leaving the GMC in April 2014 so it was also his last meeting. The Board expressed its thanks and wished him well in his new role.
Draft minutes of the Revalidation Implementation Advisory Board meeting on 18 June 2014*

Members present

Sir Keith Pearson, Chair

Mike Bewick
Nick Clarke
Niall Dickson
Frances Dow
Chris Jones
Ian Starke
Malcolm Lewis

Sol Mead
Mark Porter
Jenny Simpson
Sally Taber
Julia Whiteman
Paddy Woods

Others present

Antony Americano, Employer Liaison Adviser
Clare Barton, Assistant Director Revalidation and Specialist Applications
David Cloke, Committee Secretary, NHS Secondary Care Division, BMA
Catherine Evans, Board Secretary

Philip Finn, Head of Regulatory Development and Evaluation
Una Lane, Director Registration and Revalidation
Lindsey Westwood, Head of Revalidation,
Ben Whur, Assistant Director Performance and Improvement

* As reviewed by the Chair. The Board will be asked to approve the minutes when it meets on 30 September 2014.
Chair's business

1 The Chair shared with the Board some of the themes that had emerged from his visits to organisations across the country. In general, doctors seemed to be finding revalidation to be a positive and affirming process. They had been apprehensive at first but had gone on to find that it worked well, was well managed and seemed to be paving the way for more effective appraisals. There was also respect for the work being done by responsible officers (ROs).

2 Noting his visit to Wales Community Health Council, Sir Keith commented on the possible potential for stronger patient engagement.

3 Any concerns about the impact of the increase in revalidation recommendations in April 2014 appeared to be unfounded, with no problems presented either by ROs or the GMC. Keen to understand more about the reasons for deferrals and how these were agreed, Sir Keith found that ROs had fairly tough processes in place. There was some way to go to get boards to properly understand revalidation in relation to the overall governance agenda, but that said, in some areas this had been achieved and good governance had been established.

4 A member of the Board commented on the risk that revalidation could mean that doctors only bring the information that is necessary to the process, rather than outlining their wider aspirations. There needed to be clarity that showing what they were yet to achieve would not put their revalidation at risk.

5 Apologies were noted from Ian Finlay, Judith Hulf and Jan Warner. The following deputy attended the meeting:

a Julia Whiteman for Wendy Reid.

Minutes of the meeting on 3 March 2014

6 Sir Keith thanked Malcolm Lewis for chairing the previous meeting in his absence.

7 The Board approved the minutes as an accurate record.

GMC progress report

8 The Board considered a report giving an update on the GMC’s progress with implementing revalidation and publishing data. This included the latest information on Suitable persons (SPs), the route to revalidation for doctors without a connection, deferrals, licence withdrawal, relinquishment and voluntary erasure.
During discussion the Board noted:

a. All licensed doctors must meet the same revalidation requirements, regardless of whether they have a connection to a designated body or a SP.

b. There are no generic SPs because each SP must have a discernable link to the doctor(s) about whom they make recommendations.

c. The deferral rate amongst locums is slightly higher than other groups of doctors, but in general the revalidation process is driving organisations to strengthen their clinical governance processes.

d. It is important to be mindful of the limitations of the data at present and that it may still be too early to draw conclusions from the data.

e. The GMC would welcome advice about some specific cohorts of doctors who did not have a connection to a designated body; namely sports and exercise medicine doctors, crematorium doctors and those dealing with Section 12 cases. Members agreed to provide any information they could to help identify a SP or SPs in these areas.

The Board advised that:

a. It would be helpful to distinguish between peripatetic locums working via agencies and those in primary care. The GMC is not able to identify locums working in primary care because they are on performers’ lists so have a prescribed connection to local area teams as with all other GPs.

b. It would be useful to understand why the deferral rate among trainees in black, minority and ethnic groups is about double that of white trainees. The GMC would review the data and work with HEE and the deaneries in Wales, Scotland and Northern Ireland to understand this better.

Evaluating the impact of revalidation

The Board considered the latest information about the GMC’s appointment of a supplier to carry out the evaluation of revalidation.

The GMC would be looking to engage the Board throughout the evaluation process and would hold a workshop to help inform the initial focus of the work. The GMC had already emphasised the importance of patient and public engagement in the evaluation, with Sol Mead involved in the tender process as an observer.

The GMC would arrange a date for the workshop and circulate details to the Board.
Managing and responding to information about revalidation

14 The Board considered the GMC’s developing approach to exceptional circumstances in which information it might receive could call into question the reliability of revalidation recommendations. On 21 May 2014, the GMC hosted a workshop with the four UK health departments and NHS England to consider how to structure this process.

15 The Board noted:

a This work should complement existing activity within and outside the GMC, including fitness to practise processes, the GMC’s new Patient Safety Information Forum (PSIF), local ownership of clinical governance and the Framework for Quality Assurance (FQA) in England.

b There is still some work to be done to simplify the approach. The next step is to finalise the approach and develop a simple public-facing summary.

c The revalidation regulations give the GMC certain powers, such as to refuse to process recommendations in certain circumstances for a specified period or to defer or reschedule revalidation dates. This developing process is a way of describing how the GMC will exercise these powers.

d A key message from the recent workshop was that escalation routes are different in each country in the UK. The GMC is committed to reflecting this in its approach to managing and responding to information about revalidation.

Intelligence and advice from members

16 Delivery partner representatives shared the latest developments from their perspective with the Board.

17 In Northern Ireland, most feedback had been positive. There was no suggestion that the system was not handling the increase in number of revalidation submissions. Locums remained a critical group in terms of anxiety and providing assurance to the public.

18 In Wales, the system was coping despite large numbers. There had been significant progress in all designated bodies. Appraisal rates amongst SAS doctors had improved. The attention to quality assurance was welcomed as a way of ensuring consistent delivery across the UK.

19 In England, feedback showed the system to be working well and those involved were optimistic about the second year of revalidation.

20 In Scotland, Health Improvement Scotland’s (HIS) involvement had been very beneficial. HIS had carried out an exercise to see whether boards were sensitive to
revalidation issues. There had been a shift in focus from the mechanics of revalidation to quality of the process and outcome. Doctors were generally happy with the process.

21 In the independent sector the Competition and Marketing Authority had stated that private practice data will have to be fed into the system. This will help the process of gathering whole practice data. There were some concerns about changes to the complaints process arising from the Keogh Review, whereby all complaints would have to be seen by the ombudsman.

Any other business

22 The GMC had recently submitted its response to the report published by the Health Select Committee following the GMC’s accountability hearing. It would be published shortly by the Health Select Committee and circulated to the Board thereafter.

23 The Board discussed the need for a narrative around how revalidation is working and particularly its impact on patients. The Board noted the difficulty of attributing any developments in improving quality or safety exclusively to the introduction of revalidation and also the need to continue to emphasise that revalidation is primarily about the positive affirmation of a doctor’s fitness to practise. Board members were aware of some positive stories such as how a doctor had changed their practice on the basis of patient feedback. The Chair asked members to bring such examples to the Board.